2017 Full Submission

Title: Incorporation of narrative medicine and humanism into an integrated method of clinical training

Principal Investigator: Raymond Barfield

Email: raymond.barfield@duke.edu

School/Department: Duke University School of Medicine

Other Collaborators:

- Bethany Doran/Cardiovascular Disease
- Karen Frush/Patient Safety Center
- Aimee Zaas/Internal Medicine Residency Program
- Allison Chrestensen/Patient Family Engagement Center
- Dan Sipp/Duke Standardized Patient Training Center
- Colin Smith/Medicine-Psychiatry

Focused Question: Can an intervention incorporating the humanities using narrative medicine improve provider meaning derived from patient encounters and decrease burnout?

Background: Medicine and art have historically been intertwined, with humanism underlying the very practice of understanding disease itself. William Osler, often cited to be the father of modern medicine and among the first to champion the idea of bringing students to the patient's bedside noted that "it is much more important to know what sort of a patient has a disease than what sort of a disease a patient has."

However, as noted by Cole et al., modern medicine has become a force that can at times dehumanize not only patients, but providers themselves, leading to risks of mental health issues, job stress, and dissatisfaction with the profession [1]. Burnout is more common among physicians than individuals within the general population (38% vs. 28% p <0.001) [2] and can lead to negative outcomes for physicians themselves as well as patients [3]. In addition, burnout can lead to negative humanistic traits, with a study of medical students demonstrating burnout to be associated with increases in unprofessional behavior and a decreased altruistic view of their role in society (OR 1.8, p <0.001; OR 1.6, p<0.001, respectively) [4].

A study by Williams demonstrated that only 65% of family medicine physicians were satisfied with their work, with 87% agreeing that morale had dropped within the last 5 years. The estimated cost of turnover of a family medicine physician to a health system was $236,383 suggesting that decreasing the rate of turnover of their providers was of the utmost importance for financial viability [5]. Burnout is not limited to physicians and can occur within many disciplines within the health system, with one study showing that burnout among nurses precipitating emotional exhaustion and cynicism, which decreased nurses' professional efficacy [6].

Incorporation of the humanities into medical training using narrative medicine is gaining enthusiasm as a method that may improve resilience within providers and enhance the provider-patient relationship. Drawing from a foundation that emphasizes humane and effective treatment of other individuals, it fosters the growth of provider self-awareness and communication to encourage development of a 'voice'.

Dr. Charon, one of the leading experts in the field, noted in the Journal of the American Medical Association that narrative medicine offers the opportunity for providers to reflect on their own personal journeys and allow for a deeper empathic engagement between patient and providers [7]. Narrative medicine may take many forms, and has been piloted to include reflective writing sessions, oral story telling sessions, as well as novel techniques including improvisation, designed to allow participants to act out and react to challenging or new scenarios they may encounter.

A study performed by Krasner et al. involving mindful communication and narrative medicine demonstrated improvements in mindfulness, decreased burnout (measured by decreased scores on scales of emotional exhaustion and depersonalization), and increased personal accomplishment, empathy, and personality among providers who completed a course focused around humanism and narration [8]. A study of medical students using an improvisational theater technique to enhance communication showed improved communication skills, and an increased confidence in patient interactions [9]. Multiple medical schools and training programs have begun to incorporate training in narrative medicine and reflective writing within their curriculum, however no prior studies have examined systematically whether a comprehensive intervention centered around reflective writing practices may improve provider resilience, decrease burnout, and improve patient satisfaction.

Our intervention aims to provide the tools to providers for patient engagement, self reflection, and narration as well as the ability to practice these techniques centered around a patient interaction. We also plan to enhance the experience by fostering a sense of community among participants centered around their own reflections and experiences within the health system.

Specific Aims:

1. Improve the therapeutic relationship between provider and patient through;
2. Development of tools for provider centered around reflection and narrative methods
3. Improve resilience, sense of community, and engagement among providers

Methods:

Our ultimate plan is to develop a framework that is easily adaptable to multiple different providers including advanced practice providers, nurses, social workers, occupational and physical therapists, and physicians within multiple specialties at different levels. However, given the financial and time constraints as well as unique needs of each of these groups, we have decided to first focus on medical trainees to assess the feasibility of intervention and to address the unique pressures and challenges faced by this unique group first learning to navigate a complex health system. We will work with other

departments to roll out the intervention to other providers and adapt the intervention to their specific needs after completion of initial feasibility intervention. Ultimately, we hope to develop a program that incorporates the views of many different groups and allows for interdisciplinary conversation, encouraging collaboration and discussion among providers with many different perspectives of the health system.

The intervention will be composed of three parts:

Symposium. A one day symposium centered around reflective practices, communication, and narrative techniques designed to be thought provoking, engaging, and fun. The symposium will provide the framework for developing provider 'voice' as well as how to engage patients and to encourage comprehension and understanding of the patient on a deeper and more human level. Participants will be broken up into small groups and rotate through each workshop during the day.

Sessions:

- Mindfulness engagement led by Allison Chrestensen, who is nationally renown for her work on patient and family engagement (PFE). Participants will receive training in: communication techniques and patient activation, mindful listening, reflection on challenging situations, and tips for providing professional recommendations to patients.

- Communication using improvisational techniques. These sessions will be led by Dan Sipp, who teaches improvisational theater and is the lead standardized patient trainer at Duke. Topics to be acted out will include self portrayal, perception of others, and interpersonal interactions.

- Narrative techniques guided by Dr. Barfield who has extensive experience in teaching effective narration methods to trainees to highlight the importance of narratives in constructing the real patient's story to understand patients in the context of their own experience. Tools for expressive writing and means of disseminating pieces if participants choose.

Patient centered intervention. They will be asked to use techniques from symposium to form a deeper understanding of their patient's illness and bond with the patient.

- Using adaptation of Tell me Your Story Technique (JGIM) [11], providers will elicit a complete history of illness and the psychosocial effects and impacts it has had on the patient's life.

- Providers will be encouraged to attend procedures with patient during hospitalization as applicable.

- Providers will follow up with patient post hospital discharge to discuss any challenges they face and how they are doing.

Didactics. Six sessions of didactics focused around central humanist themes with dinner provided.

- Designed to encourage discussion between participants and a chance for reflection.

- Trainees will be provided with short pieces prior to sessions designed to be engaging and thought provoking (example NYT articles, physician narratives).

- During final session trainees will read their own patient narratives to each other and discuss their experiences.

Outcomes and Measures.

Validated scales of burnout (climate, personal burnout, subjective happiness, work-life balance), resilience, and depressive screens employed by the Duke Medical System with the assistance of the Patient Safety Center. Measures at the beginning of the symposium, and at the completion of intervention will be measured as well as three months post intervention. We will use trainees who do not wish to participate in intervention or are unable to participate as controls (between group comparison), as well as measure the change among individual participants themselves within scales compared to those who do not participate in intervention.

Data management and analysis.

Anonymous Web-based surveys will be disseminated via email by DOCR. Staff from the Duke Office of Clinical Research (DOCR) will act as an honest broker. Study personnel will not be able to match individual identity to outcomes or any other collected variable. DOCR staff will administer the survey to participants and will provide de-identified data sets back to the study team for analysis. Secure REDCap survey will be administered and data maintained on encrypted drives by DOCR.

IRB status: Submission in progress.

Challenges: The major challenge for the intervention is time management constraints for the participants themselves. As the intervention is intended to provide tools/skills for resilience, our main goal is to not overburden the participants and increase burnout with the intervention. To mitigate this, we have partnered with the internal medicine residency program at Duke to ensure logistically the intervention will fit with intern's schedule and to ensure pragmatism of intervention itself. We will elicit continual feedback to ensure that the intervention does not cause any undue stress on participants and provides a meaningful experience.

The other challenge is that the experience may elicit strong emotions from participants. In accordance with policies by the Patient Safety and Outcomes Center we will ensure survey results are confidential, but provide resources and staff will be readily available if any participant experiences emotional distress.

Budget Template:

PI Effort		
Consult costs:	$2000	Speakers for symposium
Equipment:	$2000	Survey materials, space rentals, other materials
Supplies:	$1000 $5000	DOCR statistical support Dinners, supplies for symposium,

		readings for participants
Travel:		
Total Requested:	$10,000	

Works Cited:

1. Cole, Thomas R., and Nathan Carlin. "The suffering of physicians." The Lancet 374.9699 (2009): 1414-1415.

2. Shanafelt, Tait D., et al. "Burnout and satisfaction with work-life balance among US physicians relative to the general US population." Archives of internal medicine 172.18 (2012): 1377-1385.

3. Shanafelt, Tait D., et al. "Burnout and medical errors among American surgeons." Annals of surgery 251.6 (2010): 995-1000.

4. Dyrbye, Liselotte N., et al. "Relationship between burnout and professional conduct and attitudes among US medical students." Jama 304.11 (2010): 1173-1180.

5. Williams, Eric S., et al. "Physician, practice, and patient characteristics related to primary care physician physical and mental health: results from the Physician Worklife Study." Health services research 37.1 (2002): 119.

6. Greenglass, Esther R., Ronald J. Burke, and Lisa Fiksenbaum. "Workload and burnout in nurses." Journal of community & applied social psychology 11.3 (2001): 211-215.

7. Charon, Rita. "Narrative medicine: a model for empathy, reflection, profession, and trust." Jama 286.15 (2001): 1897-1902.

8. Krasner, Michael S., et al. "Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians." Jama 302.12 (2009): 1284-1293.

9. Hoffman, Ari, Brynn Utley, and Dan Ciccarone. "Improving medical student communication skills through improvisational theatre." Medical education42.5 (2008): 537-538.

10. Barry, Michael J., and Susan Edgman-Levitan. "Shared decision making—the pinnacle of patient-centered care." New England Journal of Medicine 366.9 (2012): 780-781.

11. Chretien, Katherine C., et al. "Tell me your story: a pilot narrative medicine curriculum during the medicine clerkship." Journal of general internal medicine 30.7 (2015): 1025-1028.